Acutis Reveal™ UTI/STI/women's health test requisition

Acūtis
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CLIA ID 33D2087537 PFI 8944

Specimen identifier stickers

L 08262022
Date of birth ... / ... / ...
Patient name ...

L 08262022
Date of birth ... / ... / ...
Patient name ...

L 08262022

A Enter key information

Patient information

*Required fields

Last name* ... First name* ... MI ...
Date of birth* ... / ... / ... Gender ☐ M ☐ F
Address* ... City* ... State* ... Zip* ...
Phone number* ... Email ...

Account number

Billing information

Diagnosis code(s)* ... ☐ Copy of insurance card(s) attached
☐ Medicare ☐ Medicaid ☐ 3rd party insurance ☐ Self-pay ☐ Client bill
Primary insurance carrier ...
Policy I.D.# ... Group ...

B Order targets or individual test based on medical necessity

Acutis Reveal™ urinary tract infection test (UTI)

Clean-catch urine sample

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

☐ Perform urinalysis (UA)

☐ Perform PCR for detection of UTI pathogen(s) below
(Checking this box will indicate you are ordering all targets listed below)

- ☐ *Acinetobacter baumannii*
- ☐ *Aerococcus urinae*
- ☐ *Candida albicans*
- ☐ *Candida parapsilosis / glabrata*
- ☐ *Citrobacter freundii*
- ☐ *Citrobacter koseri*
- ☐ *Corynebacterium riegelii*
- ☐ *Enterobacter aerogenes / cloacae*
- ☐ *Enterococcus faecalis*
- ☐ *Enterococcus faecium*
- ☐ *Escherichia coli*
- ☐ *Klebsiella oxytoca*
- ☐ *Klebsiella pneumoniae*
- ☐ *Morganella morganii*
- ☐ *Pantoea agglomerans*
- ☐ *Proteus mirabilis*
- ☐ *Providencia stuartii*
- ☐ *Pseudomonas aeruginosa*
- ☐ *Serratia marcescens*
- ☐ *Staphylococcus aureus*
- ☐ *Staphylococcus epidermidis / haemolyticus / lugdunensis*
- ☐ *Staphylococcus saprophyticus*
- ☐ *Streptococcus agalactiae*
- ☐ *Streptococcus anginosus / pasteurianus*
- ☐ *Streptococcus oralis*
- ☐ *Streptococcus pyogenes*

☐ Perform antibiotic sensitivity testing (AST) for UTI pathogen(s) detected by PCR

Please note: **UA -** Yellow/red top tube **PCR & AST** - Gray top tube

Acutis Reveal™ sexually transmitted infection test (STI)

Urine sample - Aptima urine collection kit

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

☐ Perform PCR for detection of STI pathogen(s) below
(Checking this box will indicate you are ordering all targets listed below)

- ☐ *Chlamydia trachomatis*
- ☐ *Mycoplasma genitalium*
- ☐ *Neisseria gonorrhoeae*
- ☐ *Trichomonas vaginalis*

Please note: **STI** - Aptima urine tube

Genital sample - Aptima multitest swab / Aptima unisex swab

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

☐ Perform PCR for detection of STI pathogen(s) below
(Checking this box will indicate you are ordering all targets listed below)

- ☐ *Chlamydia trachomatis*
- ☐ *Mycoplasma genitalium*
- ☐ *Neisseria gonorrhoeae*
- ☐ *Trichomonas vaginalis (female only)*

Please note: **STI - Females:** genital Aptima multitest swab + **STI - Males:** Aptima unisex swab

Non genital sample - Aptima multitest swab

☐ Rectal ☐ Throat

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

☐ Perform PCR for detection of STI pathogen(s) below
(Checking this box will indicate you are ordering all targets listed below)

- ☐ *Chlamydia trachomatis*
- ☐ *Neisseria gonorrhoeae*

Please note: **STI** - genital Aptima multitest swab (male and female)

Acutis Reveal™ women's health

Vaginal swab sample - Aptima multitest swab

Date collected* ... / ... / ... Time* ... : ... ☐ AM ☐ PM

☐ Perform PCR for women's health panel
(Checking this box will indicate you are ordering all targets listed below)

- ☐ *Bacterial Vaginosis*
- ☐ *Vulvovaginal Candidiasis*

C Patient authorization

The specimen I have provided was done so voluntarily and I authorize Acutis Diagnostics to process, bill and provide results. I acknowledge and agree to the terms of the Patient Authorization and Assignment of Benefits on the back of this form.

Patient signature* ... Date ... / ... / ...

For laboratory use only
Date / time received

D Provider authorization

I certify that I have ordered all testing listed above for the medically necessary monitoring, care and treatment of above listed patient. I acknowledge that documentation to support medical necessity for all test(s) ordered is recorded in the patient's chart. I further acknowledge and agree to the Provider Authorization and Certification of Medical necessity on the back of this form.

Authorized healthcare provider signature* ... Date ... / ... / ...

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Patient authorization and irrevocable assignment of benefits

I certify that the sample was provided without tampering. I authorize Acutis Diagnostics to release the results to the ordering provider. The laboratory is authorized to bill my insurance provider(s), or any payer, whether fully or partially insured and I will irrevocably assign any payment of benefits, claims, appeal rights and interest related to the services performed by the laboratory with any payer.

I understand that in some cases, Acutis may be out-of-network or that my insurer will send payment directly to me. In the event payment is made to me, I agree to endorse the insurance check and forward it to Acutis within 30 days. My failure to forward the insurance check may result in my account being forwarded to collections or to a credit bureau. If related to no fault, I authorize assignment of benefits towards payment of services provided by Acutis. I understand that I may be responsible for charges after processing by insurance including deductible and copay/coinsurance. In the event I do not have insurance coverage, I may be fully responsible for all charges.

Provider authorization and certification of medical necessity

I acknowledge all tests are reasonable, appropriate, and medically necessary for the monitoring, care, and treatment of the patient, as documented by the patient's records. Acutis Diagnostics emphasizes the importance of testing based on medical necessity. I agree to provide documentation upon request, from the patient's medical chart, supporting medical necessity of tests ordered within 15 days of the request.

I acknowledge a listing of all applicable CPT/HCPCS codes will be made available to me upon request from the laboratory. I further acknowledge the laboratory's Annual Provider Notice is available on their website.

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